Uniform Medical Plan

Your health. Your plan. Your choice.

Preferred Hospital Billing & Administrative Manual

Washington State Health Care Authority

HCA 54-793 (1/02)

Table of Contents

Section 5: Provider Information

Section 6: Subscriber Overview

Section 7: Utilization Review

Section 8: Appendices

Section 1:
Quick Reference Notes

1.1 Important Addresses and Phone Numbers

Claims Processing and Preauthorization

Benefits information
Customer service
Claims information
Enrollee eligibility information
Medical review
Notification/Preauthorization

Uniform Medical Plan
P.O. Box 34850
Seattle, WA 98124-1850

Provider services:
Toll-free ..... (800) 464-0967
Local ..... (425) 670-3046
Fax ..... (425) 670-3199

Active enrollees:
Toll-free ..... (800) 762-6004

Retired enrollees:
Toll-free ..... (800) 352-3968

Automated Enrollee Eligibility Information

Toll-free ..... (800) 335-1062

Provider Credentialing

Change of provider status
New provider enrollment
Provider contract information

Health Care Authority
Uniform Medical Plan
P.O. Box 91118
Seattle, WA 98111-9218

Toll-free ..... (800) 292-8092
Local ..... (206) 521-2023
Fax ..... (206) 521-2001

General Program Information

Fee schedule information
Policies and procedures
Training support

Health Care Authority
Uniform Medical Plan
P.O. Box 91118
Seattle, WA 98111-9218

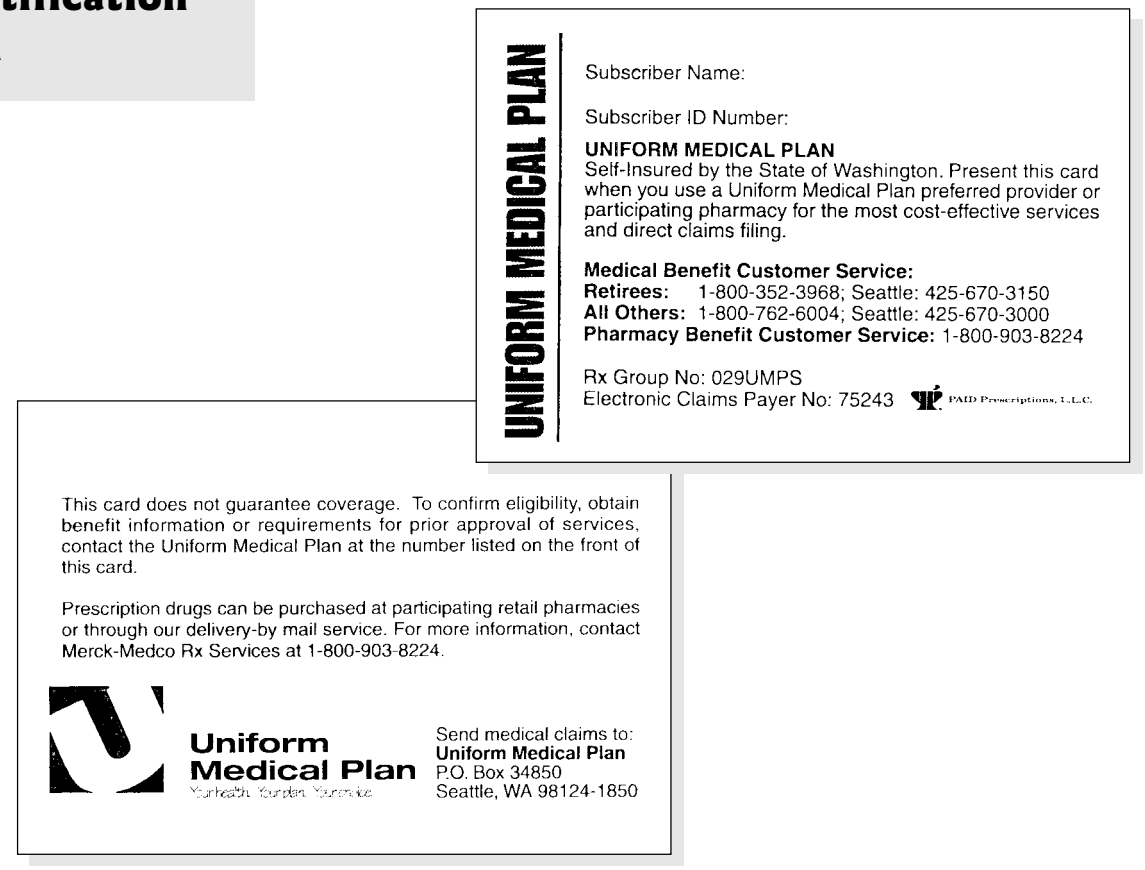
Toll-free ..... (800) 292-8092
Local ..... (206) 521-2023
Fax ..... (206) 521-2001

Web Site Information

Billing and administrative manuals, *Certificate of Coverage*, *Preferred Provider and Participating Pharmacy Directory*, fee schedules, APDRG and APC weights:
www.wa.gov/hca/ump

1.2 Sample Uniform Medical Plan (UMP) Identification Card

This is the I.D. card that confirms UMP enrollment. Please note that the subscriber identification number is prefixed by the UMP "029" group plan number.



UNIFORM MEDICAL PLAN

Subscriber Name:

Subscriber ID Number:

UNIFORM MEDICAL PLAN
Self-Insured by the State of Washington. Present this card when you use a Uniform Medical Plan preferred provider or participating pharmacy for the most cost-effective services and direct claims filing.

Medical Benefit Customer Service:
Retirees: 1-800-352-3968; Seattle: 425-670-3150
All Others: 1-800-762-6004; Seattle: 425-670-3000
Pharmacy Benefit Customer Service: 1-800-903-8224

Rx Group No: 029UMPS
Electronic Claims Payer No: 75243 PAID Prescriptions, L.L.C.

This card does not guarantee coverage. To confirm eligibility, obtain benefit information or requirements for prior approval of services, contact the Uniform Medical Plan at the number listed on the front of this card.

Prescription drugs can be purchased at participating retail pharmacies or through our delivery-by mail service. For more information, contact Merck-Medco Rx Services at 1-800-903-8224.

Uniform Medical Plan
Yourhealth. Yourplan. Yourchoice.

Send medical claims to:
Uniform Medical Plan
P.O. Box 34850
Seattle, WA 98124-1850

1.3 Claims Submission Information

Paper claims (UB-92) should be mailed within 60 days of service to the UMP claims payer at the following address:

Uniform Medical Plan
P.O. Box 34850
Seattle, WA 98124-1850

Claims with missing, inaccurate, or invalid information will be denied or sent back for clarification and resubmission.

Electronic claims submission is a more efficient way of doing business. If you are already connected to ENVOY-NEIC, submit your UMP claims to payer I.D. number 75243. If you are not connected, call ENVOY-NEIC at (800) 366-5716 for more information on how to get connected to send claims electronically.

1.4 Provider Enrollment Information

To promote quality of care, UMP benefits are structured to encourage enrollees to use the services of providers who participate in the UMP Preferred Provider Network. Enrollees typically pay coinsurance of 40 percent or more when they use nonpreferred providers.

As a preferred UMP facility, you are required to refer patients to other preferred providers or facilities. The UMP recognizes that most providers have established referral patterns. If the providers you routinely refer to are nonpreferred, but are interested in joining the UMP provider network, please refer them to the Provider Services Division by calling (800) 292-8092 or (206) 521-2023. Please note, however, that all providers must meet UMP credentialing criteria prior to receiving preferred provider status.

1.5 Preauthorization/ Notification

To provide notification for select principal/primary diagnoses; to request preadmission certification for skilled nursing facility admissions; or to request preauthorization for organ transplants, hospice care, home health care, durable medical equipment, or other services as required by the *Certificate of Coverage*, call (800) 464-0967.

Section 2:
Program Outline/Reimbursement

Questions regarding development of reimbursement rates and policies? Call (206) 521-2023 or (800) 292-8092.

2.1 Overview of the Uniform Medical Plan

The Uniform Medical Plan (UMP) is a self-insured, preferred provider medical plan for public employees and retirees. It is sponsored by the Public Employees Benefits Board (PEBB) and administered by the Washington State Health Care Authority (HCA).

The UMP provides coverage for many alternative/complementary, medical, surgical, and obstetric services; chemical dependency and mental health treatment; organ transplants; and prescription drugs. All enrollees have benefits for routine preventive care, vision and hearing examinations, and diabetic education.

See the UMP *Certificate of Coverage* for deductible, coinsurance, and copayment requirements, as well as for a complete description of benefits.

2.2 Inpatient Reimbursement for Acute Care Hospitals (Excluding Low-Volume and Children's Hospitals)

The primary basis for the UMP inpatient hospital payment is the All-Patient Diagnosis Related Group (APDRG) per case system. With some specific exceptions, hospitals with at least 1,000 cases per year for all payers other than Medicare and Medicaid (as determined from the Department of Health's Comprehensive Hospital Abstract Reporting System, or CHARS) are reimbursed for inpatient care on a per-case basis. Exceptions include children's hospitals which, along with low-volume hospitals, are paid on a per diem basis; specialized providers, such as the Seattle Cancer Care Alliance; and certain categories of cases described on the following page. The reimbursement for APDRG claims is determined by multiplying the applicable APDRG relative weight by the hospital-specific conversion factor.

APDRG Relative Weight: Each APDRG is assigned a weight that measures the relative cost of treating patients in that APDRG compared to the cost of treating the average patient.

Conversion Factor: The conversion factor is a dollar amount, specific to each hospital. The conversion factor is developed from an initial base rate that represents statewide average operating costs per case. The initial base rate is adjusted on a hospital-specific basis which recognizes capital expenditures, area wage differences, direct and indirect teaching costs, increased resources required to treat low-income patients, margin, uncompensated care, and inflation.

Cases excluded from per-case payment:

- Cancer research centers
- Organ transplants (except cornea) covered by the UMP, which are reimbursed at a hospital-specific percent of charge rate
- Psychiatric, chemical dependency, and rehabilitation APDRGs, which are reimbursed on a hospital-specific per diem basis
- Low-volume APDRGs
- Patients discharged/transferred to another distinct-part unit of the same hospital
- Patients who leave against medical advice
- Patients discharged alive on the same day of admission (except normal delivery and normal newborn patients), which are reimbursed at a hospital-specific percent of charge rate

2.3 Inpatient Reimbursement for Low-Volume and Children's Hospitals

The UMP has defined a set of low-volume hospitals and children's hospitals for which per-case reimbursement is not applicable. These hospitals are reimbursed using either a medical or surgical per diem. The reimbursement is determined by multiplying the applicable per diem rate (medical or surgical) by the length of stay for the case. The applicable per diem rate is determined by classifying a case into an APDRG, each of which has been defined as either medical or surgical.

The per diem rates for the low-volume hospitals were developed in a manner similar to the conversion factors for per-case hospitals, starting with statewide medical and surgical per diems, which were then adjusted for hospital-specific circumstances. The per diem rates for the two children's hospitals are based on historic, hospital-specific data. In addition, a hospital-specific percent of allowed charges rate is used for transplants occurring at the children's hospitals.

2.4 Reimbursement for Hospital Outpatient Services

Services provided in a hospital outpatient setting are currently reimbursed using the Ambulatory Payment Classification (APC) methodology, at a percent of allowed charges or according to the UMP Professional and Clinical Lab Fee Schedule, depending on the type of service and provider type. Please refer to Payment Addendum A of your *Preferred Provider Agreement for Hospitals*.

APC Relative Weights: The UMP weights are the same as those used by CMS. For current CMS relative weights, please refer to the either the UMP web site at *www.wa.gov/hca/ump* or the CMS web site at *www.hcfa.gov/medicare/hopsmain.htm*.

Conversion Factor: The conversion factor is a dollar amount, specific to each hospital that is developed similarly to that of the APDRG inpatient conversion factor.

Hospitals/facilities excluded from APC reimbursement:

- Ambulatory Surgical Centers
- Children's hospitals
- Critical access hospitals
- Military and Veteran's hospitals
- Out-of-state hospitals
- Psychiatric hospitals
- Rehabilitation hospitals
- Rural hospitals, as defined by the Department of Health's Peer Group I

2.5 Advantages of Network Participation

There is a strong financial incentive built into the UMP's benefit design to encourage enrollees to use preferred providers. Specifically, enrollees who use preferred hospitals pay a $200 per day copay up to a maximum of $600 **per year** for inpatient treatment. Subscribers who choose to receive services at an in-area nonpreferred hospital are responsible for the difference between billed charges and 60 percent of the allowed amount.

Example: Mr. Jones is admitted to Healthy Hospital, which is **not** a UMP-preferred hospital. Allowed charges for a four-day stay equal $4,000. Assuming the annual deductible has been met, the UMP will pay $2,400 and the enrollee responsibility is $1,600.

If Mr. Jones had been admitted to a UMP-preferred hospital, his responsibility would have been $600.

Section 3:
Billing Instructions for Inpatient and Outpatient Services

3.1 Definition of Inpatient

An inpatient is defined as a Uniform Medical Plan (UMP) enrollee who has been admitted to the hospital and is expected to remain 24 hours or longer.

For APDRG-based preferred providers, the APDRG payment amount includes all pre-admission, diagnostic, appliance, pharmaceutical, operative, treatment, and room and board charges for the patient, for the period beginning one calendar day prior to the date of admission and extending through date of discharge.

If the hospital has an ambulatory surgery program or a "day patient" program where an enrollee receives services which require a hospital stay of less than 24 hours, services must be billed as outpatient.

The UMP will work with the hospital should any question arise as to appropriate site of care or to address any unique service arrangements provided by the hospital.

3.2 Billing Form and Coding Standards

For cases that are not reimbursed on an APDRG per-case or per diem basis, a semi-private room rate is used to determine allowed charges. The UMP may pay for private rooms (revenue codes 111-119 and 141-149) when determined to be medically necessary.

UMP hospital inpatient and outpatient claims must be submitted using the Health Care Financing Administration form, HCFA-1450, also known as Uniform Billing Form (UB-92). Incomplete claims will cause either a delay or denial of claims payment. The UMP recognizes data elements as defined by the National Uniform Billing Committee (NUBC).

The most current versions of the ICD-9-CM diagnosis and procedure codes or CPT-4 and Health Care Financing Administration Common Procedure Coding System (HCPCS) Level II codes are required for billing purposes. As the diagnosis and procedure codes are revised quarterly/annually by CMS and the AMA, the updated codes should be used for UMP claims, beginning at the same time that the codes become valid for use with Medicare claims.

All diagnosis and procedure codes on the claim form will be edited for validity and accuracy using the Inpatient Medicare Code Editor or Outpatient Code Editor, as applicable. Claims with invalid, out-of-date, non-specific, or inaccurate codes will be sent back to the hospital for clarification, resulting in delayed reimbursement.

Standard UB-92 revenue codes are required on all service lines of a claim.

3.2.1 Non-Covered Revenue Codes

Charges for the following services should be listed as noncovered (Form Locator 48); they will not be considered for payment.

Revenue Codes	Description
180 - 189	Leave of Absence
220	Special Charges
256	Drugs/Experimental
257	Pharmacy - Non-Prescription
399	Other Blood Storage and Processing
670	Outpatient Other Special Residence
723	Newborn Circumcision
819	Other Donor
941, 948, & 949	Other Rx Svcs/Weight Loss
960 - 989	Professional Fees
990 - 999	Patient Convenience Items

Revenue code 220, Special Charges, requires submittal of additional information identifying and justifying the charges.

Revenue Codes 960 through 989, Professional Fees, are not covered when billed on a UB-92 form. These services must be billed separately with an appropriate CPT code on a HCFA-1500 form. Where appropriate, the CPT "26" modifier indicating that the charges represent the professional component of the service **must** be billed on the HCFA-1500 form. These fees are not bundled into an APDRG or a per diem reimbursement, but will be paid separately if submitted on a HCFA-1500 form. If your hospital bills for these professional services using the hospital's own federal tax identifier, the claim will be paid as if the physician were a preferred provider, using the resource-based relative value scale (RBRVS) fee schedule as determined by the UMP. The patient may **not** be billed for professional charges that exceed the UMP allowable charge.

3.2.2 Services Prior to Admission

For cases paid on an APDRG per-case basis, all services provided within one calendar day prior to admission will be considered part of the admission and covered by the APDRG reimbursement rate. This includes, but is not limited to, radiology, pathology, and emergency room services. Any charges for services on the calendar day prior to admission must be submitted on the inpatient UB-92 bill and not billed separately as an outpatient service. The Statement Covers Period, Form Locator 06, should reflect the admission date (From) and discharge date (Through).

3.2.3 Outpatient Billing Instructions

The following revenue codes are accepted by the UMP when billed without a corresponding CPT or HCPCS Level II code.

Revenue Code	Description
250	Pharmacy - General Classification
251	Pharmacy - Generic Drugs
252	Pharmacy - Non-Generic Drugs
253	Pharmacy - Take Home Drugs
254	Drugs Incident to Other Diagnostic Services
255	Drugs Incident to Radiology
257	Non-Prescription Drugs
258	IV Solutions
259	Other Pharmacy
260	IV Therapy - General Classification
262	IV Therapy/Pharmacy Services
263	IV Therapy/Drugs/Supply Delivery
264	IV Therapy/Supplies
269	Other IV Therapy
270	Medical - Surgical Supplies
271	Non-Sterile Supply
272	Sterile Supply
273	Take Home Supplies
274	Prosthetic/Orthotic Devices
275	Pacemaker
276	Intraocular Lens
277	Oxygen - Take Home
278	Other Implants
279	Other Supplies/Devices
280	Oncology - General Classification
289	Other Oncology
370	Anesthesia - General Classification
371	Anesthesia - Incident to Radiology
372	Anesthesia - Incident to Other Diagnostic Services
374	Acupuncture
379	Other Anesthesia

3.2.3 Outpatient Billing Instructions (continued)

Revenue Code	Description
390	Blood - General Classification
399	Other Blood Storage and Processing
700	Cast Room - General Classification
709	Other Cast Room
710	Recovery Room - General Classification
719	Other Recovery Room
720	Labor Room/Delivery - General Classification
721	Labor

All other revenue codes that are billable on a hospital outpatient claim must contain a CPT/HCPCS code. Claims with missing or invalid CPT/HCPCS codes will be rejected by the UMP.

3.2.4 APC Bill Types

Bill type (form locator 4) is the code that indicates the specific type of bill (inpatient, outpatient, etc.).

The bill types that are reimbursed under UMP's APC reimbursement methodology are:

13X Hospital Outpatient (including ASC)

14X Hospital Outpatient—other

3.2.5 Line Item Dates of Service

The UMP requires line item dates of service to be reported on all outpatient bills for each line where a HCPCS code is required, including claims where the "from" and "through" dates are the same. Omission of these dates will delay processing.

3.2.6 Service Units

The UMP recognizes a service unit as the number of times a service or procedure being reported was performed.

3.2.7 Modifiers - CPT (Level I)

The UMP will accept the following:

-25 Modifier for Evaluation & Management services

-50 Bilateral

-52 Reduced services

3.2.7 Modifiers - CPT (Level I) (continued)

-58	Modifier for staged or related procedures
-59	Modifier for distinct services
-73	Discontinued outpatient hospital surgical procedure (ASC) or diagnostic procedure/service prior to the administration of anesthesia
-74	Discontinued outpatient hospital surgical procedure (ASC) or diagnostic procedure/service after the administration of anesthesia
-76	Repeat procedure by same physician
-77	Repeat procedure by another physician
-78	Return trip to the Operating Room
-79	Unrelated procedure during post operative period

3.2.8 Modifiers - HCPCS (Level II)

LT	Left Side
RT	Right Side
E1	Upper Left Eyelid
E2	Lower Left Eyelid
E3	Upper Right Eyelid
E4	Lower Right Eyelid
FA	Left Hand, Thumb
F1	Left Hand, Second Digit
F2	Left Hand, Third Digit
F3	Left Hand, Fourth Digit
F4	Left Hand, Fifth Digit
F5	Right Hand, Thumb
F6	Right Hand, Second Digit
F7	Right Hand, Third Digit
F8	Right Hand, Fourth Digit
F9	Right Hand, Fifth Digit
LC	Left Circumflex Coronary Artery
LD	Left Anterior Descending Coronary Artery
RC	Right Coronary Artery
QM	Ambulance Service (arranged by provider)
QN	Ambulance Service (furnished by provider)
TA	Left Foot, Great Toe
T1	Left Foot, Second Toe
T2	Left Foot, Third Toe
T3	Left Foot, Fourth Toe
T4	Left Foot, Fifth Toe

3.2.8 Modifiers - HCPCS (Level II) (continued)

T5 Right Foot, Great Toe
T6 Right Foot, Second Toe
T7 Right Foot, Third Toe
T8 Right Foot, Fourth Toe
T9 Right Foot, Fifth Toe

3.2.9 Repetitive Services

Please follow Medicare billing guidelines.

3.2.10 Late Charges

Late charges must be submitted as an adjustment to the original claim.

3.2.11 Outpatient Code Editor (OCE) Edits

The UMP will follow CMS guidelines and applicable versions of the OCE . The UMP recognizes that some Medicare inpatient only and noncovered services may be appropriate in an outpatient setting and will reimburse those procedures under the percent of billed charge portion of your hospital agreement.

3.2.12 Discounting

For multiple surgical procedures furnished under the same operative session, discounting will be as follows: 100% for the procedure with the highest weight, 50% for any additional surgical procedures. Surgical procedures terminated prior to the induction of anesthesia will be paid at 50% of the APC payment.

3.2.13 APC Outlier

The UMP will follow CMS outlier methodology for APCs.

Section 4:
Claims Procedures

4.1 APDRG Grouping of Claims

At the time an inpatient claim is submitted, the Uniform Medical Plan (UMP) will assign the claim to an All-Patient Diagnosis Related Group (APDRG). Hospitals are not required to group claims prior to submission. The grouping and pricing methodology used is based on patient discharge date.

4.2 Payment Arrangements

Payment rates are stipulated in the contract between the hospital and the UMP. Inpatient claims are paid using the rates in effect on the date of discharge. Outpatient claims are paid using the date of service.

All features of the UMP's benefit design are applied based on the admission date of the patient. This includes, for example, determination of covered services, deductibles, copayments, and provider status (e.g., preferred or nonpreferred). If the provider loses preferred provider status, payment is based on the contractual arrangement in effect when the enrollee was admitted to the hospital.

4.3 Paper Claim Submission

Providers are required to use the UB-92 claim form. Claims with invalid ICD-9, CPT, and/or HCPCS Level II codes will be denied. Incomplete claims will cause either delay or denial of claims payment. Inpatient hospital claims will not be accepted on an interim basis. For inpatient hospital claims, only those for final discharge billing will be processed. Inpatient claims from skilled nursing facilities will be accepted for processing on a monthly basis.

4.3.1 Timely Submission of Claims

Claims for covered services provided to a UMP enrollee should be submitted within 60 days of the date of service. The UMP will not process claims submitted more than 365 days after the date of service. Under exceptional circumstances when the UMP is secondary and the primary payer has not paid on a timely basis, this provision may be waived upon approval by the UMP.

To request a waiver, send a written explanation of the circumstances to:
Manager, Customer Service
Uniform Medical Plan
P.O. Box 34850
Seattle, WA 98124-1850

4.3.2 Process for Resubmission of Claims and Adjustments

To resubmit a claim that was previously denied for correction or clarification, simply resubmit the claim containing the requested information with your regular batch.

To request an adjustment to a previously paid claim, preferred providers should contact the UMP by phone at (800) 464-0967, or write to:

Uniform Medical Plan
P.O. Box 34850
Seattle, WA 98124-1850

If the UMP agrees that the claim warrants adjustment, the provider may be required to submit the corrected claim and attach a letter stating the reason that the claim should be adjusted. Adjustment claims are identified by a "6" entered in Form Locator 4 (type of bill), third digit.

4.3.3 Subscriber and Provider Appeals Procedure for Denied Claims

If a UMP enrollee feels that a claim has been incorrectly processed or payment wrongly denied, it is the responsibility of the enrollee to contact the UMP. Enrollees may contact UMP toll-free at 1-800-762-6004, or locally in the Seattle area at 425-670-3000. If the problem is not resolved to the satisfaction of the enrollee, he or she may appeal the decision by filing a written notice of appeal with the UMP. Details of this process can be found in the enclosed *UMP Certificate of Coverage*.

4.3.4 Audit and Right of Recovery Policy

The UMP's right to audit, inspect, and duplicate records maintained on enrollees by preferred providers is discussed in the audit section of the contract between the UMP and the provider.

Similarly, the UMP's right to seek prompt refund from the provider for any duplicate, erroneous, or excess payments, or to deduct the amount overpaid from future payments, is discussed in the refunds section of the contract between the UMP and the provider.

4.3.5 Patients' Rights to Confidentiality

It is the responsibility of the provider to keep audit, billing, payment, medical, and other patient-related information for UMP enrollees confidential, except as necessary for performance of the contract between the UMP and the provider, unless required by law to do otherwise.

4.3.6 Coordination of Benefits (COB) Requirements

To receive payment when the UMP is in a secondary payer position, submit a copy of the original UB-92 claim form, along with a copy of the Explanation of Benefits (EOB) or Detail of Remittance (DOR) provided by the primary payer. When the UMP is the secondary payer, nonduplication of benefits is applied to the processing of the claim. The UMP compares the financial responsibility of the enrollee under both the UMP and the primary payer. If the enrollee's financial responsibility under the primary plan is more than what it would have been under the UMP, the UMP pays the difference between the two and the enrollee is responsible for the lesser of the two copays. The following examples show how it works.

Hospital inpatient *COB example*
(assuming the annual deductible has already been satisfied)

Determine payments assuming no UMP coverage

Hospital allowed charges	$ 5,000
Primary payer (PP) pays	$ 4,000
PP enrollee responsibility	$ 1,000

Determine payments assuming no primary payer coverage

UMP would have paid	$ 4,700
UMP enrollee responsibility	$ 300

Compare enrollee copays

Primary payer copay	$ 1,000
UMP copay	$ 300
UMP will pay difference	$ 700
Enrollee will pay	$ 300
Primary payer pays	$ 4,000
Hospital receives	$ 5,000

Hospital outpatient *COB example*
(assuming the annual deductible has already been satisfied)

Determine payments assuming no UMP coverage

Hospital allowed charges	$ 400
Primary payer (PP) pays	$ 320
PP enrollee responsibility	$ 80

Determine payments assuming no primary payer coverage

UMP would have paid	$ 360
UMP enrollee responsibility	$ 40

Compare enrollee copays

Primary payer copay	$ 80
UMP copay	$ 40
UMP will pay difference	$ 40
Enrollee will pay	$ 40
Primary payer will pay	$ 320
Hospital receives	$ 400

4.3.7 Explanation of Benefits (EOB)

When the claim is paid, the patient receives an Explanation of Benefits (EOB) which shows the original submitted charges, any non-covered charges, the patient's responsibility, and the amount paid by the UMP.

The patient's EOB will also indicate when portions of the submitted charge have not been covered because the amount charged exceeds the contracted allowance for the service. The patient is not responsible for these charges and **cannot be** balance billed for them.

Patients may be confused when receiving EOBs for cases which have been paid either by APDRG or per diem arrangements, since the payments will bear no direct relationship to the billed charges. In order to reduce their confusion and minimize the number of follow-up phone calls from patients questioning their bills, a standard message will be printed on all EOBs for claims paid under an APDRG or per diem arrangement stating, "Per hospital contract with the Uniform Medical Plan, billed charges do not apply." (Please note: For outpatient services, if the APC allowed charge is greater than the billed charge, the member's coinsurance will be based on the billed charge. The UMP will reimburse the difference to the provider.)

4.3.8 Detail of Remittance (DOR)

Providers will receive a Detail of Remittance (DOR) from the UMP, which will indicate the amount of charges being reimbursed for each claim. Sample DORs can be found in Appendix 3. The DOR identifies the patient by name and identifier (029 + subscriber's identification number) and captures the claim number assigned by the UMP. Then, for each service line of the claim, the DOR lists the service date, the procedure code of the service, submitted charges, non-covered charges and message code, preferred provider discounted amount, patient's responsibility (DED/COPAY), the amount paid, and the remaining balance for which the patient may be billed. It is recommended that providers not bill the patient for the applicable deductible or coinsurance until after a DOR has been received substantiating reimbursement by the plan.

4.3.9 Interim Claims Policy: Inpatient Claims

For inpatient admissions, interim claims are not accepted from preferred hospitals. UB-92 claim forms with a "30" in Form Locator 22 (Patient Status) and/or a "2", "3", or "4" entered in Form Locator 4 (Type of Bill), 3rd digit, will be returned to the hospital. Only "admit through discharge" claims ("1" in Form Locator 4, 3rd digit) are accepted for payment.

Under exceptional circumstances of hardship, a hospital may appeal on a case-specific basis to the UMP for a waiver of this policy. To appeal for a waiver, contact:

Manager, Customer Service
Uniform Medical Plan
P.O. Box 34850
Seattle, WA 98124-1850

4.4 Cost Outlier Payment Policy: Inpatient Claims

Outlier claims are those claims with unusually high or low costs. Catastrophic losses for which a hospital may be at risk are the major focus of the UMP's outlier policy.

High-Cost Outliers: High-cost outlier status is attained when the cost (defined as allowed charges multiplied by the inpatient percent of charges rate specified in the hospital's contract) exceed the specific outlier threshold for the APDRG. The outlier threshold is the greater of: (a) two times the APDRG payment (APDRG weight multiplied by the hospital's conversion factor) or (b) $15,000.

When high-cost outlier status is reached, the UMP will reimburse 100% of the costs that exceed the outlier threshold.

Low-Cost Outliers: Low-cost outlier claims are those claims for which allowable charges are less than: (a) two standard deviations below the mean charge (of the log distribution) for the APDRG, or (b) 5 percent of the inlier, whichever is greater. Low-cost outlier claims are reimbursed the APDRG payment amount or the contracted percent of allowed charges, whichever is less.

4.5 Late Claims and Relationship to High-Cost Outlier Payment Policy: Inpatient Claims

Late claims are defined as those claims that contain charges submitted by the hospital to the UMP after submission of the final claim. These claims are identified by a "5" entered in Form Locator 4 (Type of Bill), 3rd digit, of the UB-92 form.

For claims paid on an APDRG or per diem basis, all charges on late claims will be denied and the hospital notified with a message indicating that the case has been paid in full under the APDRG or per diem payment system.

In the case of claims paid on an APDRG per-case basis, it is possible that the allowable charges on a late claim could be sufficiently great to qualify the case for high-cost outlier reimbursement. If a hospital believes that this situation has occurred, **it is the hospital's responsibility to notify the UMP,** and request a review of the claim for possible readjudication. Such review will not occur automatically when late claims are received.

Submit written appeals for high-cost outliers to:

Manager, Customer Service
Uniform Medical Plan
P.O. Box 34850
Seattle, WA 98124-1850

4.6 Transfer Payment Policy: Inpatient Claims

APDRG-Based Preferred Providers: An APDRG-based preferred hospital that transfers an enrollee to another hospital is reimbursed the APDRG payment amount or the hospital's contracted percent of allowed charges, whichever is less. These cases are commonly referred to as transfer-out cases, and are defined on the UB-92 by a code of "02" entered in Form Locator 22, Patient Status.

Exceptions to the above payment policy are for APDRG 456 (Burn Transfer), and APDRGs 639 and 640 (Neonate Transfers). These APDRGs are reimbursed the APDRG payment amount or as low-volume APDRGs, whichever is appropriate. Low-volume APDRGs are defined in the contract between the hospital and the UMP and are reimbursed the contracted percent of allowed charges. All transfer-out cases should be coded "02" in Form Locator 22.

Discharges/transfers to subacute care within the preferred hospital are reimbursed the lesser of the APDRG payment amount or the hospital's contracted percent of allowed charges. The acute care portion of the stay will be reimbursed according to the reimbursement methodologies outlined in Section 2 of this manual.

There is no special reimbursement arrangement for the receiving (also known as the transfer-in) hospital.

Per Diem-Based Preferred Providers: Transfer cases (into or out of the hospital) are reimbursed at the applicable medical or surgical per diem rate.

4.7 Readmission Payment Policy: Inpatient Claims

Inpatient cases in which a readmission for the same or a similar condition occurs within 30 days of a previous discharge may be reviewed by the UMP on a retrospective basis.

Provisions for retrospective review, refunds, and the dispute resolution process are covered in the sections Medically Necessary Services, Refunds and Dispute Resolution, respectively, of the contract between the UMP and the hospital.

4.8 Identification of Transplant Cases: Inpatient Claims

Subject to preauthorization, those cases that group transplant APDRGs and all other organ transplants (except cornea) covered by the UMP are paid at the contracted percent of allowed charges rate.

All other organ transplants will be identified at the time that prenotification/preauthorization certification occurs and will be adjudicated manually according to the contracted percent of allowed charges rate.

4.9 Balance Billing Policy

Preferred providers agree to accept the UMP hospital payment as full compensation for covered services, and agree not to bill enrollees for any amounts above the contracted payment amount.

The enrollee is responsible for any applicable deductible, coinsurance, copayment, and/or payment for non-covered services. The preferred provider is liable for services determined to be medically unnecessary upon retrospective review, unless a waiver signed by the patient is on file with the hospital substantiating that the patient knew the services would not be covered prior to the provision of these services.

When the UMP is secondary, and the primary payer has a contractual agreement with the hospital, the hospital may not balance bill the UMP for charges in excess of the primary payer's contracted amount.

The patient **cannot** be billed for:

- Any amounts above the maximum allowance;
- Any portion for which the UMP is responsible; or
- Any covered services for which medical necessity cannot be established by the UMP. An exception to this requirement is made if the patient understood, prior to receiving the service(s), that the service(s) would not be covered by the UMP, and agreed in writing to assume financial responsibility for the service(s).

The patient **can** be billed for:

- Any applicable deductible, copayment, or coinsurance;
- Any charges for UMP-excluded services; or
- Any charges for services that exceed the benefit limit.

4.10 Itemized Billing Statement and Medical Records

The UMP does not normally require itemized billing statements with the UB-92 claim form. However, for inpatient claims in excess of $50,000, outpatient claims in excess of $10,000, or claims that are suspended or audited for other reasons, itemized billing statements and copies of invoices substantiating usual and customary charges may be requested by the UMP.

Medical records are required for claims identified by the Medicare Code Editor as "questionable admissions," based on a principal diagnosis which is not usually sufficient justification for admission to an acute care hospital.

In addition, the UMP may request medical records for a case in which it is not clear that the treatment performed is covered or is medically necessary. In these situations, however, a special request will be made to the hospital.

Section 5:
Provider Information

5.1 Provider Requirements

Uniform Medical Plan (UMP)-preferred hospitals and hospital-based physicians agree to comply with the requirements outlined in this section.

5.1.1 Credentialing

- Maintain licensure, registration, and/or certification in the state of Washington.
- Maintain professional liability insurance coverage with limits of liability as determined by the UMP.
- Meet all other credentialing requirements documented in your Preferred Provider Agreement as determined by the UMP.
- Accept UMP fee schedules and follow UMP policies and procedures.

5.1.2 Billing

Call (425) 670-3046 or (800) 464-0967.

- Bill the UMP your usual and customary fee.
- Submit claims on UB-92 (HCFA-1450) forms for hospital or skilled nursing facility inpatient or outpatient claims, or HCFA-1500 forms for professional fees, within 60 days after the covered services are rendered. Claims cannot be submitted later than 365 days from the date of the covered service(s), except as noted in Section 4.3.1.
- Ensure that enrollees are not billed for any amounts above the maximum allowance.
- Collect applicable deductibles, copayments, and coinsurance from UMP enrollees after receiving the detail of remittance documenting the amount the enrollee can be billed.

5.1.3 Referrals and Authorizations

- Refer enrollees to UMP-preferred providers and preferred facilities, except where no appropriate preferred provider is available or in case of an emergency.
- *The Preferred Provider and Participating Pharmacy Directory* located in Appendix 2 of this manual contains a listing of UMP-preferred providers by city and specialty. Preferred home health and hospice agencies, including infusion therapy providers, are listed by counties served. This

directory is updated annually. Nonpreferred providers can apply for preferred status by contacting the UMP. All providers must meet the UMP selection criteria prior to receiving preferred provider status. Because the UMP's preferred provider network continues to expand, it is important to verify a provider's preferred status prior to making a referral.

- Call the UMP to obtain preauthorization for organ transplants, hospice care, home health care, durable medical equipment, cardiac and pulmonary rehabilitation, biofeedback, cochlear implants, growth hormones, obstetric services provided by limited-license providers, positron emission tomography (P.E.T.) scans, skilled nursing facility admissions, and temporomandibular joint (TMJ) surgery.
- Notify the UMP of hospital stays exceeding 10 days and admissions for certain diagnoses, as requested by the UMP. See Section 7 of this manual for detailed information about the UMP utilization review requirements. In addition, see the UMP *Certificate of Coverage* found in Appendix 1, which outlines other notification/preauthorization requirements, as well as defines those services which are covered, those which have limitations, and those which are excluded.

Section 6:
Subscriber Overview

**Patient questions regarding benefits,
preferred provider status, claims payment?
For information on active employees, call (800) 762-6004.
For information about retirees, call (800) 352-3968.**

6.1 Subscriber Requirements

Subscriber education is an important factor in ensuring the timely and appropriate payment of health care benefits. UMP subscribers are instructed to follow these guidelines when obtaining health care services:

- Choose a provider from the *Preferred Provider and Participating Pharmacy Directory,* as found in Appendix 2 of this manual, or call the UMP customer service number.
- Verify that the services they are obtaining are covered by the UMP by referring to their UMP *Certificate of Coverage*, as found in Appendix 1 of this manual, or by calling the UMP.
- Identify themselves as a UMP enrollee when calling for an appointment.
- Present their identification card at the time services are rendered.
- Remind their physician to refer them to UMP-preferred providers and to admit them to UMP-preferred network hospitals.
- Obtain preauthorization from the UMP for: biofeedback, cochlear implants, growth hormone therapy, organ transplants, hospice care, home health care, durable medical equipment, cardiac and pulmonary rehabilitation, positron emission tomography (P.E.T.) scans, obstetric services provided by limited-license providers, skilled nursing facility admissions, and temporomandibular joint (TMJ) surgery.
- Promptly remit applicable deductibles, coinsurance, copayments, and/or payment for non-covered services. (Please note: For outpatient services, if the APC allowed charge is greater than the billed charge, the member's coinsurance will be based on the billed charge. The UMP will reimburse the difference to the provider.)

If patients have questions regarding benefits, preferred provider status, or payment of claims, please refer them to the UMP at the above-referenced numbers.

Section 7:
Utilization Review

Notification/preauthorization questions?
Call (425) 670-3046 or (800) 464-0967.

7.1 Utilization Review Requirements

7.1.1 Overview

Utilization management/quality assurance reviews are conducted by the Uniform Medical Plan (UMP).

The UMP's utilization management program includes review of certain medical services prior to, during, and after they are delivered. Reviews conducted include:

- Notification of hospital admissions for select diagnoses to identify potential UMP case management patients;
- Retrospective review of inpatient hospital admissions and outpatient services; and
- Preauthorization for specific services/procedures.

The purpose of the review is to determine the need for case management, screen for medical necessity, ensure that services are being provided in the most appropriate setting, and confirm that claims have been coded and billed accurately. Such reviews help to:

- Monitor quality of care;
- Ensure that treatment is necessary and consistent with good medical practices;
- Discourage unnecessary care;
- Save health care dollars; and
- Identify chronic and catastrophic cases appropriate for case management.

7.1.2 Notification of Hospital Admissions

The purpose of this program is to allow for the earliest possible identification of UMP patients for whom case management services may be appropriate. Any hospital stay exceeding 10 days must be reported to the UMP.

Also, please call the UMP to report complex patient cases that may be assisted by our nurse case managers. The UMP is currently in the process of re-evaluating its diagnosis admission list. When the revised list is available, the attending physician or hospital representative should call the UMP to report any UMP enrollees who are admitted to the hospital for one of these diagnoses. The medical condition of the enrollee will be evaluated to determine if case management is indicated.

Notification is not required when Medicare or another benefit plan that requires notification or preauthorization is the primary payer.
Note: The notification process does not involve approval for medical necessity or preauthorization of services. However, these admissions may be subject to retrospective (postpayment) review.

7.1.3 Case Management

Voluntary Case Management

Case management is a collaborative process that may include a nurse case manager coordinating with physicians, hospitals, skilled nursing facilities, or other facilities by telephone or on-site visits. This will require the cooperation of the facility and the attending physician, with the consent of the enrollee.

Generally, cases are identified as candidates for case management through the notification process. However, a facility or provider may identify a patient with a chronic or catastrophic illness as a potential candidate for case management. In this instance, the facility or provider should call the UMP at (888) 759-4855.

Required Case Management

The UMP Medical Director may review an enrollee's medical records and determine whether the enrollee's use of medical services is unsafe, potentially harmful, excessive, or medically inappropriate. Based on this review, the UMP may require an enrollee to participate in and comply with a case management plan as a condition of continued payment for services under the UMP.

Case management may include, but not be limited to, designating a primary provider to coordinate care and/or designating a single hospital and/or pharmacy to provide covered services or medications. The UMP has the right to deny payment for any services received outside the required case management plan with the exception of medically necessary emergency services provided outside the service area.

7.1.4 Retrospective Review

Certain admissions may be subject to retrospective (postpayment) review. This process involves an assessment of the:

- Medical necessity of the admission and/or procedure(s) performed;
- Appropriateness of the treatment setting;
- Patient's status upon discharge;
- APDRG validation;
- Billing discrepancies; and
- General quality of care delivered.

Providers/facilities are responsible for supplying the UMP with any requested medical records or documentation required to complete the audit and reviews. Audits may be done onsite. Failure to comply with such requests may result in denial of payment for services.

7.1.5 Review Criteria and Quality Screens

UMP nurses use written UMP review criteria and quality screens when conducting retrospective case reviews and preauthorization screening. If the nurse determines that a case does not meet the review criteria, the case will be referred to the UMP Associate Medical Director. The decision to approve or deny is made by the UMP Associate Medical Director after consultation with the attending physician when appropriate, and is based on medical experience and evidence-based medicine.

7.1.6 Preauthorization

To ensure that standard benefits are received by the enrollee, prior authorization must be received by the plan before receiving the following services:

- Biofeedback
- Cardiac/pulmonary rehabilitation
- Cochlear implants
- Durable medical equipment (over $1,000 or three months' rental)
- Growth hormones
- Home health services (exceeding 14 consecutive days or two hours per day)
- Hospice care, including hospice respite services
- Obstetric services provided by limited-license providers or in birthing centers
- Organ transplants
- Positron emission tomography (P.E.T.) scans
- Skilled nursing facility admissions
- Temporomandibular joint (TMJ) surgery

See the current UMP *Certificate of Coverage* for specific information.

7.1.7 Requirements for Skilled Nursing Facilities (SNF): Medicare-Certified Only

Preauthorization is required for skilled nursing facility benefits, and treatment must meet medical necessity criteria. The enrollee must require continued services of skilled medical or allied health professionals that cannot be provided on an outpatient basis. To request preauthorization, call the UMP at the numbers referenced at the beginning of this section.

Medical review is not required when Medicare or another benefit plan that requires preauthorization is the primary payer and is providing benefits. If Medicare or another benefit plan is denying coverage, preauthorization, including medical review for medical necessity, will be required by the UMP.

At the time of preauthorization, all cases will be screened for case management referral.

7.1.8 Reconsiderations and Appeals

If the preauthorization or claim is denied, the enrollee or authorized representative, including the treating provider, may request an appeal of the decision or claim by writing to:

Uniform Medical Plan Medical Review
P.O. Box 34578
Seattle, WA 98124-1578

Appeals must be submitted within 120 days (except for claim appeals) after receipt of the notice of rejection or the action that led to the complaint. Claim appeals must be filed within 15 months of the date of service or date of written denial.

Further information on the appeals process can be found in the current version of the UMP *Certificate of Coverage*.

Section 8:
Appendices

1. Uniform Medical Plan *Certificate of Coverage*
2. *Preferred Provider and Participating Pharmacy Directory*
3. Detail of Remittance (DOR), Inpatient - (Example)
4. Detail of Remittance (DOR), Outpatient - (Example)

Appendix 1:
Uniform Medical Plan *Certificate of Coverage*

Appendix 2:
Preferred Provider and Participating Pharmacy Directory

Appendix 3:
Detail of Remittance (DOR)
Inpatient - (Example)

UNIFORM MEDICAL PLAN	**WASHINGTON HOSPITAL**		PROV #: 234565678-00 PAGE 1
PO BOX 34850	1234 11TH ST SW	SEE LAST PAGE FOR	TAX # 000000000
SEATTLE, WA 98124-1850	SEATTLE, WA 98133	EXPLANATION OF CODE	DATE: 09/ 28/ 1999
1-800-464-0967			DRAFT #: **0A-7055025**
(425) 670-3046			ENVOY/NEIC ID # 75243

PATIENT NAME / ACCOUNT #	BENEFIT ID # / CLAIM #	SVC DATE	REV/PROC CODE	#	BILL AMOUNT	NONCOV'D	CODE	DEDUCTIBLE	COPAY COINS	PPO DISCOUNT AMOUNT	PATIENT BALANCE	AMOUNT PAID
PATIENT, EMPLOYEE	029111111111	07/14/01	450 99213	1	252.50	0.00		0.00	21.46	37.87	21.46	193.17
C21423101		07/14/01	450 17000	1	56.50	0.00		0.00	4.80	8.47	4.80	43.23
		07/14/01	450 17003	1	46.00	0.00		0.00	3.91	6.90	3.91	35.19
			CLAIM TOTAL		**355.00**	**0.00**		**0.00**	**30.17**	**53.24**	**30.17**	**271.59**
											PAYMENT	

271.59

TOTAL PAID

Appendix 4
Detail of Remittance (DOR)
Outpatient - (Example)